5925 Calculation of Outpatient Indigent Care Allowance

The outpatient indigent care allowance will be calculated for each qualifying hospital, as formulated below, based on its expenses attributed to outpatient services provided to low-income persons.

GAEXPOUT	For each qualifying hospital, expenses attributable to outpatient services provided to low-income persons as determined according to section 5915 above.
ΣGAEXPOUT	The sum of GAEXPOUT for all qualifying hospitals.
TOTMAX	The maximum funding to be distributed which shall be the lesser of (1) the target funding of section 5980 or (2) ΣGAEXPOUT.
RATIO	The proportion of each qualifying hospitals GAEXPOUT to □GAEXPOUT, calculated as follows: *RATIO = GAEXPOUT / ΣGAEXPOUT*
OUT_ICA	The annual outpatient indigent care allowance for each qualifying hospital, calculated as follows: *OUT_ICA = RATIO x TOTMAX*

5930 Payment of Indigent Care Allowances

Each qualifying hospital's annual outpatient indigent care allowance (OUT_ICA), divided by twelve, will be the amount which will be paid to the hospital for each month of the year July 1 through the subsequent June 30th.

5940 Federal Upper Payment Limit

Payments of the indigent care allowance by the Wisconsin Medicaid program will be discontinued if and when total payments for outpatient hospital services during a year July 1 through June 30 will exceed the upper payment limit requirements found at 42 CFR 447.321.

5960 Combining Historical Financial Statistics of Recent Hospital Combinations

Hospital combinings result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant.

When hospitals combine into one hospital, the required years of historical data may not be available for the combined operation for one or more rate years after the combining occurs. Whenever a required year of data is available for a full year of the combined hospital operation, then that year of data is used. However, if a full year is not available for the combined operation, then data of the individual hospitals for the required years is combined or added together for the calculations under this §5900.

5980 Target Funding for Outpatient Indigent Care Allowance.

The total target funding for the outpatient indigent care allowance is $8,506,151 for each rate year July 1, 1999 through June 30, 2000 and July 1, 2000 through June 30, 2001 .

6000 ADMINISTRATIVE ADJUSTMENT ACTIONS

For Hospitals In Wisconsin Only (Previously Section VI)

6100 Introduction.

The Department provides an administrative adjustment procedure through which an in-state hospital may receive prompt administrative review of its outpatient reimbursement under the circumstances described in section 6800. Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment. If the hospital disputes the staff determination, the administrative adjustment can be forwarded for review to the Administrative Adjustment Committee (AAC). The AAC provides a recommendation to the Department regarding the disputed adjustment. A detailed description of the policies and procedures for processing administrative adjustments is in the Appendix. Administrative adjustment actions are not available to out-of-state hospitals (reference §5000).

6200 Hospital's Submission of Request for Adjustment.

A hospital must deliver a written request to the Department for an administrative adjustment within the time constraints of the 60 day rule below. An adjustment may be requested for interim payment rates and for reimbursement final settlements.

In order to be considered sufficient, the hospital must specify the following items in its written request: (1) that the request applies to its outpatient reimbursement, *(2)* either the effective date of the interim payment rate or the final settlement year for which an adjustment is being requested and *(3)* the specific matter listed in §6800 below for which the hospital is making its request for an adjustment. The Department may, at its discretion, pursue clarification of and subsequently accept an incomplete request.

Requests should be addressed to the Bureau of Health Care Financing, Hospital Unit, 1 West Wilson Street, Room 250, P. O. Box 309, Madison, Wisconsin 53701-0309. The FAX telephone number is (608) 266-1096 but may change without notice.

If a hospital had requested an adjustment to an interim payment rate, the Department will generally include the adjustment in subsequent interim rate calculations or final settlement calculations without the hospital specifically requesting the adjustment. (Adjustment §6810 below allows a hospital to withdraw such an adjustment the Department made at its discretion.) *However, it is the hospital's responsibility to assure that any administrative adjustment it wants are included in its interim rates and in its final settlement calculations.* If not included, the hospital must submit a request for the adjustment within the appropriate time limit.

6300 The 60 Day Due Date Rule.

The effective date of an administratively adjusted payment rate shall depend on when the hospital requests the adjustment or the Department initiates the adjustment. The effective date shall be established according to the following criteria.

6301 Definition, "Delivery date".

The U.S. Postal Service postmark date will be considered delivery date of a mailed administrative adjustment request. If delivered by FAX machine, the inscripted date from the Department's FAX machine shall be considered delivery date. Delivery date under any method, other than U.S. mail or FAX, shall be the day the Department receives delivery.

The Department is not responsible for written requests which are lost in transit to the Department. If lost, the hospital must demonstrate to the satisfaction of the Department that a "delivery date" had been established according to the above criteria. The Department recommends that hospitals use registered return-receipt U.S. mail in order that they have documentation of the postmark date and that the Department received the request.

6302 Interim Rates, Due Date for Request for Administrative Adjustment.

The rate, as determined under §4200 and §4300, serves as an interim rate until final settlement. Within the 60 day period after the date of a notice of interim rate approval, a hospital must deliver a written request to the Department for an administrative adjustment in order for the requested adjustment to take effect on the original effective date of the interim rate. If a hospital delivers a written request more than 60 days after the date of a notice of interim rate approval, then any adjusted rate shall take effect on the first of the month following the delivery date. The Department's notice of the adjusted interim rate does not start a new 60 day period.

A *notice of interim rate approval* is a written notice to a hospital from the Department which lists the hospital's interim rate and its effective date and also states that the hospital has 60 days to request an administrative adjustment.

6303 Final Settlement, Due Date for Request for Administrative Adjustment.

A hospital must deliver a written request to the Department for an administrative adjustment within the 60 day period after the date of the notice of final settlement. A request will be denied if it is delivered more than 60 days after the date of the notice of final settlement. It should be noted that the rates per outpatient visit which apply to a final settlement may be administratively adjusted at the time of the final settlement.

A *notice of final settlement* is a written notice to a hospital from the Department which identifies the results of the final settlement calculation for a specified fiscal year of the hospital. It will also state that the hospital has 60 days to request an administrative adjustment.

6400 Administrative Adjustments Initiated by the Department.

The Department may initiate an administrative adjustment not requested by the hospital and incorporate the adjustment into its calculation of an interim rate or into its final settlement calculations. However, the Department may initiate an adjustment after it has sent a notice of interim rate approval or a notice of final settlement to the hospital. The date the Department initiates the adjustment is the date of any written notice the Department may provide to the hospital which notifies the hospital that the Department has initiated an administrative adjustment. If the date of that notice is within 60 days after the date of a notice of an interim rate approval or a notice of final settlement, the adjustment shall take effect on the original effective date of the interim rate or the final settlement. If more than 60 days, the adjustment shall take effect on the first of the month following the date of the Department's notice that it is initiating an adjustment. If the Department's adjustment causes a reduction of reimbursement, the hospital may request an administrative adjustment within the above 60 day rule period.

6500 Correction of Inappropriate Calculations, Coincident With An Adjustment.

The Department may find an inappropriate calculation of a hospital's interim rate or final settlement coincident with its processing an administrative adjustment. An inappropriate calculation is defined in §6820 below. The Department's correction of the inappropriate calculation will be effective the date the administrative adjustment is effective. If a requested adjustment is denied, the correction of the inappropriate calculation found by the Department will be effective the date the requested adjustment would have been effective had it been approved. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the corrected interim rate or final settlement if the correction causes a reduction of reimbursement.

For example, the adjustment requested by a hospital provided a $10 rate increase. An inappropriate calculation found by the Department caused a $2 decrease. Even though the net effect is an $8 rate increase, the isolated effect of the Department's correction caused a $2 decrease. As a result, the hospital will have a new 60 day period for requesting an administrative adjustment.

6600 Reduced Payment Possible.

If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been applied, the lesser amount will be paid. If an administrative adjustment results in an increased payment, the increase shall be paid.

6700 Withdrawal.

Once Department staff has calculated the adjustment requested by a hospital and notified the hospital of the results the hospital cannot withdraw its request for the administrative adjustment. However, adjustment §6810 below allows a hospital to withdraw an adjustment under certain circumstances at the time of final settlement. The Department cannot withdraw an administrative adjustment after it has notified the hospital that it has initiated an administrative adjustment.

6800 Criteria for Administrative Adjustments

Administrative adjustments are available for the following specific circumstances or occurrences.

6810 Withdrawal of Adjustment Under Special Case

As a general practice, the Department will include an administrative adjustment in a final settlement which the hospital had previously received in its interim rate for the settlement year. Similarly, if a hospital requested an adjustment to a previous year's interim rate, the Department may include the adjustment in a current year's interim rate without a specific request from the hospital. *However, it is the hospital's responsibility to assure that any administrative adjustment it wants are included in its interim rates and in its final settlement calculations.* If not included, the hospital must submit a request for the adjustment within the appropriate time limit.

This administrative adjustment allows the hospital to reverse such an adjustment made by the Department. The hospital may request that the adjustment be taken-out of the final settlement or an interim rate.

Request Due Date: The above 60 day rule applies (see §6300).

Adjustment Procedure: The Department will recalculate the final settlement or the interim rate at issue.

6820 Correction of Inappropriate Calculation of Interim Rate or Final Settlement

Qualifying Determination: The interim payment rate or a final settlement must have been inappropriately calculated under the rate setting plan.

(1) The application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or

(2) A clerical error in calculating the hospital's payment rate, or

(3) Incorrect or incomplete application by the Department of provisions of the reimbursement methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment.

Request Due Date: The above 60 day rule applies (see §6300). However, for corrections initiated by the Department, the Department may correct a rate retroactively effective to the rate's original effective date if the rate had been based on data which was not audited by the Wisconsin Medical Assistance Program.

Adjustment Procedure: The hospital must supply data or information to the Department to support an adjustment. The data must be able to be audited currently or at a latter time by the Department. An audited cost report of the hospital may need to be reopened in order to resolve the adjustment request.

Reopening Cost Report: Either the hospital or the Department may request that the Medicaid audit contractor reopen an audited cost report in order to correct an error in the data on which an interim rate was based or on which a final settlement was based. The administrative adjustment request for the correction of an interim rate or a final settlement which requires the reopening of an audited cost report must be delivered within the time limit of the above 60 day rule.

> For example, the base year of a new provider, ABC Hospital, is its fiscal year ending December 1991. On July 12, 1994 it received a notice of final settlement for its fiscal year ending December 1992. It immediately submitted an administrative adjustment request to reopen its 1991 audited cost report in order to correct data on which its rate per outpatient visit was calculated. The 1991 cost report was reopened, the outpatient rate per visit corrected and its 1992 final settlement corrected. ABC Hospital also requested its final settlement for 1991, which had been completed a year earlier, be corrected. That administrative adjustment request was denied because it had <u>not</u> been submitted within 60 days of the 1991 settlement (i.e., the time limits of the 60 day rule).

An audited cost report may be reopened only if all of the following conditions are satisfied: (1) the dollar effect is $5,000 or greater, (2) the statistic affecting the payment rate is in error by 5% or more, <u>and</u> (3) the request for reopening and the necessary data is submitted to the audit contractor within five years from the end date of the reporting period for which the cost report is being reopened. The audit contractor will apply these conditions.

The Department may request that the audit contractor obtain additional data or perform additional audit tests when reopening a cost report. The audit contractor's charge to the Department for reopening a cost report may be billed to the provider if it was the provider's error that was in need of correction.

Legal Review Pursued by Hospital: Corrections of payment rate calculations must be pursued by a hospital through this administrative adjustment before the hospital can pursue legal review of its rate calculation. If a hospital does pursue any available legal review after requesting an administrative adjustment, the Department will withdraw any proposed rate adjustment it has offered to the hospital as to any given issue, and the Department will not put the adjusted payment into effect. If the adjusted payment has been put into effect and it is an increase over the payment previously in effect, the adjusted payment will be retroactively rescinded to the date it had been made effective and replaced with the payment in effect prior to the adjustment. In such a case, increased payments at the adjusted rate will be recovered by the Department.

6830 Case-Mix Adjustment

A case-mix adjustment is an adjustment to the rate per outpatient visit (as determined according to §4200) that provides for changes in the mix of services from the outpatient base year to the final settlement year.

Request Due Date: The above 60 day rule applies (see §6300). The Department may provide up to a 30 day extension of the request due date if the hospital delivers a written request for the extension within the period of the 60 day rule. It should be noted that if a case-mix adjustment is requested and the Department calculates a decrease in the rate per outpatient visit, the Department will pay at the reduced rate. The purpose for providing for an extension is to allow a hospital adequate time to gather the necessary data to make an informed decision as to whether or not it wants to request a case-mix adjustment. The hospital may request from the Department a tabulation of its charges to the Wisconsin Medical Assistance Program (WMAP).

Adjustment to Interim Rate: The Department may provide an interim case-mix adjustment to the rate per outpatient visit which was determined under §4200. Upon consultation with the Department, the hospital must provide the Department sufficient information in order that a reasonable and reliable estimate of the case-mix adjustment for the final settlement year can be calculated by the Department.

Final Settlement Adjustment: The case-mix adjustment will be calculated for the full final settlement year according to the methodology described on the next page.

	CALCULATION FOR CASE MIX ADJUSTMENT	RESULT
1	For the outpatient base year, total direct cost from Schedule B of the cost report for each revenue producing cost center (i.e., service area) divided by the total charges for each cost center.	Ratio of direct cost -to- charges for each cost center.
2	Result 1 for a cost center multiplied by T-19 outpatient charges (i.e., charges to WMAP) for the respective cost center.	Gross T-19 base year direct costs for each cost center.
3	Result 2 for a service area divided by number of T-19 services for base year for the service area.	T-19 base year cost per unit of service in each service area
4	For the settlement year, number of T-19 services performed in a service area divided by total T-19 services for the year in all service areas.	Percentage of T-19 services in each service area in settlement year
5	Result 4 for a service area multiplied by total number of T-19 services performed in all service areas in the base year.	Adjusted number of base year T-19 services for each service area
6	Result 3 multiplied by Result 5 for each respective service area.	Adjusted base year T-19 direct cost for each service area.
7	Sum of Result 6 for all service areas minus the sum of Result 2 for all service areas.	Gross increase or decrease in direct cost.
8	Result 7 divided by total number of T-19 services performed in base year.	Increase or decrease in direct cost per service or visit.
9	Result 8 multiplied by 1.00 plus the applicable base year cost adjustment factor from §4200.	Increase or decrease adjusted to final settlement year.
10	Result 9 plus the rate per outpatient visit for final settlement year as determined per §4200..	Rate per outpatient visit for final settlement year, adjusted for case-mix.

6840 Adjustment for Major Capitalized Expenditures

For Final Settlement Years Ending On and After November 1, 1993

This administrative adjustment provides for an updating of the capital cost component of a hospital's rate per outpatient visit. It provides a means through which a hospital can have its rate per outpatient visit adjusted to recognize current major expenditures which improve, add to, or replace existing equipment and structures which are directly or indirectly used for outpatient services. The following criteria apply to adjustments of the rate per outpatient visit for any final settlement year which ends on and after November 1, 1993.

Qualifying Determination: The hospital's total capitalized depreciable assets at the end of the hospital's final settlement year have increased by an amount which is 25% of total capitalized depreciable assets at the beginning of the outpatient base year. Qualification shall be determined by comparing the amount of capitalized depreciable assets reported in the hospital's audited financial statements for the hospital's final settlement year and its outpatient base year.

Request Due Date: The above 60 day rule applies (see §6300). However, for interim rates effective November 1, 1993, a request for an adjustment may be delivered by March 15, 1994 in order for the adjustment to be retroactive to November 1, 1993.

Definition. Capitalized depreciable assets include depreciable land improvements, buildings, fixed equipment and moveable equipment which are owned by the hospital and such assets leased by the hospital through capitalized leases and excludes capitalized construction-in-progress.

Definition. The *audited financial statements* of the hospital are its independently audited financial statements with a statement of audit scope and opinion by a certified public accountant.

Adjustment of Interim Rate: The Department may provide a capital adjustment to the interim rate which was determined under §4200.. Upon consultation with the Department, the hospital must provide sufficient information in order that reasonable and reliable estimates can be made by the Department. The Department will estimate if the hospital will likely qualify for an adjustment to the rate per outpatient visit upon final settlement. If it is estimated that the hospital will likely qualify, then an estimate of the final expected capital payment can be included in the interim payment rate.

Final Settlement Adjustment: Final determination of whether or not the hospital qualifies for the adjustment will be made at the time of the final settlement calculation for the final settlement year in which the adjustment is to be allowed. If the hospital qualifies, the rates per outpatient visit for the final settlement year will be adjusted to consider the major increase in capitalized expenditures.

An updated capital cost component will be added to and the base year capital cost component subtracted from the rates per outpatient visit which had been established for the final settlement year according to §4200.. The results are the adjusted rates per outpatient visit.

An *updated capital cost component* of the rates per outpatient visit will be determined for the settlement year based on cost information from the audited Medicaid cost report for the final settlement year. The hospital's allowed outpatient costs attributed to WMAP recipients will be multiplied by the ratio of total allowed hospital capital costs to total allowed hospital costs. The resulting gross amount will be divided by WMAP recipient outpatient visits for the final settlement year. The result is the updated capital cost component which will be reduced by the capital reduction factor of §4200. for dates of service on and after July 1, 1992.

The *base year capital cost component*, determined under §4200. will be calculated as follows. The hospital's allowed outpatient costs attributed to WMAP recipients for the outpatient base year will be multiplied by the ratio of total allowed hospital capital costs to total allowed hospital costs for the outpatient base year. The resulting gross amount will be divided by WMAP recipient outpatient visits for the outpatient base year and then increased by the applicable base year cost adjustment factor of section §4200.. The result is the base year capital cost component which will be reduced by the capital reduction factor of §4200 for dates of service on and after July 1, 1992.

6842 Major New Construction Project

For Final Settlement Years Ending Before November 1, 1993

A hospital, which has had a major new construction project for which the related capital expenses are not included in the cost report for the outpatient base year, may request an adjustment to its rate per outpatient visit.

In order to qualify for an administrative adjustment, the capital expenditure must be a single, identifiable construction or renovation project that was undertaken, and not an agglomeration of small or unrelated construction projects. A major construction project involves a one-time capital expenditure exceeding 25% of the cost to construct the entire original facility and must be designed to improve or add to or replace an existing patient-care structure. The hospital requesting this adjustment must furnish audited financial statements or a certified statement by a CPA firm which identifies the hospital's depreciation, leases, capital-related interest, and total hospital costs for the fiscal periods to be specified by the Department.

A new capital cost component of the rate per outpatient visit will be determined which includes recognition of the major construction project. Cost information from the audited cost report specified by the Department shall be used for this calculation. The capital cost attributable to WMAP (Wisconsin Medical Assistance Program) recipient outpatient services shall be determined by multiplying the hospital's allowed outpatient cost attributable to WMAP recipient outpatients by the ratio of total allowed hospital capital costs to total allowed hospital costs. The resulting gross amount shall be divided by WMAP recipient outpatient visits for the cost report period. The Department shall index this new capital cost per WMAP outpatient visit by the DRI/McGraw Hill, Inc. Hospital Market Basket Index. The result is the new capital cost component which shall be included in and replace the prior capital cost component of the hospital's rate per outpatient visit.

The prior capital cost component of the hospital's rate per outpatient visit shall be subtracted from the hospital's rate per outpatient visit. Cost information from the audited cost report used to calculate the rate per outpatient visit shall be used. The capital cost attributable to WMAP recipient outpatient services shall be determined by multiplying the hospital's allowed outpatient cost attributable to WMAP recipient outpatients by the ratio of total allowed hospital capital cost to total allowed hospital costs. The resulting gross amount shall be divided by WMAP recipient outpatient visits for the cost report period. This prior capital cost component per WMAP outpatient visit shall be subtracted from the hospital's rate per outpatient visit.

6850 Adjustment to Rural Outpatient Adjustment Percentage for Recognition of Out-of-State Medicaid Services

Qualifying Determination. This adjustment allows a hospital, which provides services covered by a Medicaid program of a state other than the Wisconsin Medical Assistance Program (out-of-state Medicaid), to have those out-of-state Medicaid services recognized in determining its eligibility for the rural hospital adjustment and amount of its adjustment.

Request Due Date : The above 60 day rule applies (see §6300). However, for interim rates effective November 1, 1993, a request for an adjustment may be delivered by March 15, 1994 in order for the adjustment to be retroactive to November 1, 1993.

Adjustment Procedure: The hospital will need to report charges for inpatient and outpatient services provided during its fiscal year which ended in 1992 which were paid (or payable) by out-of-state Medicaid programs. These charges will be included in the calculation of the rural hospital adjustment under §4300. The data may be audited at a latter date and, if the data is found to be in error, the Department will recover any overpayment that result from the erroneous data.

6851 New Base-Year for Combining Hospital Affected by Section 4840

Background: Hospitals that combine into one operation with one Wisconsin Medicaid provider number on or after July 1, 1995, either through merger or consolidation or a hospital absorbing the operation of another hospital through purchase or donation, receive a base outpatient rate-per-visit according to section 4840. This rate is a mix of the base rates-per-visit of the previous individual hospitals as calculated from each individual hospital's base-year cost report. However, if the newly combined hospital requests a case-mix adjustment under section 6830, it may not be possible to calculate. A reliable case-mix adjustment requires a consistent unit of service between the outpatient base-year and the final settlement year. The units by which the combined hospital counts or measures the services it provides may not be comparable to the units used by the previous individual hospitals. (For example, in one hospital a unit of an item may be in ounces. In the other hospital, it may be in liters.) It is very unlikely that the base-years (as defined in section 3000) of the previous individual hospitals can be case-mix adjusted to the combined hospital's settlement fiscal year.

Qualifying Criteria: A hospital that receives a combined average base rate-per-visit under section 4840 may request a new base-year on which to establish new rate-per-visit. The new base-year will be the hospital's first full fiscal year that begins on or after six months after the effective date of the hospital merger, consolidation or absorption. This adjustment is available to a qualifying hospital for services provided on and after January 1, 1996.

Request Due Date for This Section 6851: The 60-day rule of section 6300 applies but requests delivered by June 30, 1996 may be effective January 1, 1996.

Interim Adjustment: The Department may provide an interim adjusted rate-per-visit until the final adjustment described below can be completed. Upon consultation with the Department, the hospital must provide sufficient information so the Department can establish an interim adjustment that will approximate the final adjustment.

Final Adjustment Procedure: A new base rate-per-visit will be calculated when the audited Medicaid cost report is available for the new base-year. The new base-year will be the combined hospital's first full fiscal year that begins on or after six months from the effective date of the hospital merger, consolidation, or absorption.

1. The audited cost, which is attributed to outpatient services provided Medicaid recipients, will be identified.
2. The costs from step 1 will be reduced for the cost of services attributable to laboratory services reimbursed under the laboratory fee schedule of the Wisconsin Medicaid program. These are services covered by the clinical laboratory reimbursement defined in section 3000.
3. The remaining costs from step 2, after excluding the laboratory costs, will be deflated to the base-year described in section 3000 by applying the appropriate DRI/McGraw Hill, Inc. hospital market basket index.
4. The result from step 3 will be increased by the adjustment factors listed in item 3 of section 4200 to the final settlement year. (The final settlement year is described in section 3000.)
5. The clinical diagnostic laboratory reimbursement for laboratory services provided in the new base-year will be added to the adjusted amount from step 4.
6. The sum from step 5 will be divided by the number of outpatient visits of Medicaid program recipients in the new base-year. This is the new rate-per-visit for outpatient services.

For settlement years following the above new base-year, the hospital can request a case mix adjustment under section 6830. The above new base-year will be the base-year for use in a case-mix adjustment.

An Example Case:

On March 10, 1996, Hospital-A combines with Hospital-B resulting in a combined hospital, Hospital-C. Hospital-C has December ending fiscal years. The outpatient rates per visit of Hospital-A and Hospital-B are averaged together according to §4840 to be Hospital-C's rate-per-visit effective March 10, 1996.

In April 1999, Hospital-C's audited 1996 cost report is available and a settlement is calculated for the fiscal year. The Department notifies the hospital of the results. Within 60 days of the notification, the hospital requests a new base-year under the administrative adjustment of §6851. The new base-year will be its fiscal year January through December 1997, which is its first fiscal year that began on or after six months from the date of the hospitals combining, that is, March 10, 1996.

In June 2000, Hospital-C's audited 1997 fiscal year cost report is available. An outpatient rate-per-visit is calculated from that cost report according to the adjustment procedure described above. Given the new base-year rate-per-visit, the settlements for Hospital-C's 1996 and 1997 fiscal years are completed.

It should be noted that Hospital-C waited until its settlement to request the above administrative adjustment for a new base-year. The hospital could have requested the adjustment earlier and received an interim adjusted rate-per-visit. As done in the example, a final base rate-per-visit woul have been calculated when its 1997 audited cost report (its new base-year) became available.

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6860 Combining Two Settlement Years, Only for Settlement Years Ending Between July 1993 and June 1995

This adjustment only applies to final settlements calculated after November 1, 1993.

Qualifying Determination: This adjustment is available to a hospital if (1) the first settlement year of the hospital which ends after June 30, 1993 results in a final settlement that is limited by the rates per outpatient visit as determined under §4200 (i.e., limited by item 2 of §4100) and, (2) if for the subsequent final settlement year the allowable audited cost of outpatient services recipients is reimbursed (i.e., not limited by items 1, 2 and 3 of §4100).

Request Due Date: The hospital may request this adjustment only after completion of the second or 'subsequent' final settlement year described above. The above 60 day rule applies to the request (see §6300). No interim adjustment to the outpatient rate per visit is available.

Adjustment Procedure: The final settlement calculations for the two settlement years described above will be combined into one final settlement calculation.

6890 Critical Access Hospital Interim Cost Payment Adjustment

This administrative adjustment provides for an interim cost payment for outpatient services to critical access hospitals. Under this provision, critical access hospitals may request an adjustment to be paid allowable costs for outpatient services. Hospital's that receive an adjustment under this section are not eligible to receive a rural hospital adjustment under section 4300.

Qualifying Determination: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by HCFA, and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

Interim Cost Payment Adjustment: The Department may provide an interim cost payment until a final cost settlement can be calculated. The interim cost payment adjustment will be established based on a hospital's most recent audited cost report. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final settlement. If the information provided by the hospital to the Department is not sufficient to provide a reasonable estimate of the final settlement, no adjustment will be made until sufficient data is available or when the final settlement can be completed, whichever comes first.

State statute requires that payments, including critical access hospital reimbursement, be limited to cost.

The cost of air, water and land ambulance service are not reimbursable as outpatient hospital services for outpatient critical access hospital providers. These services must be billed by a Wisconsin Medicaid certified ambulance provider.